Book of the month

Heroin Addiction Care and Control: the British System 1916 to 1984

'The plain truth is that there is no British System', said John Strang and Michael Gossop in 1994[1]. For a considerable time, people have debated what constituted the British system of drug treatment and control. The term is generally taken to mean the approach that operated from the 1920s to the 1960s but perhaps the British system is one of those things that you don't know you have until it's gone.

Over the twentieth century, treatment for an initially small number of addicts changed from private care, which could involve detoxification or the prescription of heroin or morphine, to the entrance of NHS practitioners, and then, as the number of drug users increased, the removal of treatment from primary care and into new specialist health service treatment centres. Initially these clinics prescribed injectable heroin and methadone, but, under the leadership of some influential London psychiatrists, they began to move to oral methadone, encouraging others to do the same. Heroin prescribing became a minority activity, and those who advocated it were increasingly shunned by their colleagues[2,3].

The medical prescription of opioid drugs to addicts had been officially sanctioned on the recommendation of the 1926 Rolleston Report which defined drug addiction as an illness and therefore the responsibility of doctors[4]. Doctors could prescribe opioids for:

> 'Persons for whom, after every effort has been made for the cure of the addiction, the drug cannot be completely withdrawn, either because:-
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> (i) Complete withdrawal produces serious symptoms which cannot be satisfactorily treated under the ordinary condition of private practice; or
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> (ii) The patient, while capable of leading a useful and fairly normal life so long as he takes a certain non-progressive quantity, usually small, of the drug of addiction, ceases to be able to do so when the regular allowance is withdrawn'[5].

While this may have not constituted a 'system' in terms of a centralized policy or set of rules, the clinical freedom it allowed doctors and the underlying spirit of compassion towards addicts certainly existed in the minds of many of those in policy and treatment. One of those minds was Bing Spear, who saw himself as defending Rolleston's legacy through his work in the Home Office Drugs Inspectorate. His book, *Heroin Addiction Care and Control: the British System 1916 to 1984*[6], has been awaited with much anticipation, even impatience.

Henry Bryan 'Bing' Spear joined the Home Office Drugs Inspectorate in 1952 and became its Chief in 1977 until ill health forced him to retire in 1986. At the beginning of his career, 56 heroin addicts were known to the Home Office, and by his retirement there were many thousands. Heroin use had moved from a small, mainly metropolitan phenomenon supplied chiefly by doctors and the overspill from their prescriptions, to a habit affecting all parts of the country met by a labyrinthine international black market.

The response to the widening scale and nature of the country's drug use which established the specialist clinics under the leadership of psychiatrists was, according to Spear, 'an unmitigated disaster' because 'the moral high ground was seized by a small group within the medical establishment, and by psychiatrists in particular, who over the years succeeded in imposing their own ethical and judgemental values on treatment policy'. He opposed the move from heroin to methadone in the clinics, believing it was led by dogma rather than evidence. The publication of this examination of what happened to the UK's heroin prescribing last time around is particularly timely when David Blunkett has been revisiting the topic. The Home Secretary has been talking about encouraging doctors to prescribe heroin, and the relevant clinical guidelines are currently being prepared.

Described as 'a most unusual civil servant', Spear worked not only to police the medical prescribing of dangerous drugs, which was part of his duties in the Inspectorate, but also took a personal interest in the welfare of individual drug users. The almost legendary status he achieved in the drugs field, and his deep knowledge of the 'scene', account for the excitement with which the book (left to Joy Mott, his literary executor and friend, to complete) was awaited.

There are, in its publication, a number of surprises. Many people expected an autobiography, but the book begins some time before his birth in 1916; and, even after he becomes actively involved, Spear is somewhat absent from the descriptions of historical developments. The book aims more for a detached history, although informed by the personal, and is copiously referenced. There will be disappointment for those who, primed by the recent tendency of cabinet ministers to reveal their most intimate indiscretions, were looking for 'insider' takes of the events he was party to. Most of the historical sources he used are available to academic historians, although his extensive knowledge clearly directed his quest. Joy Mott's editing has produced a seamless, elegantly written document which will be of great value to researchers and students. She has, apparently, removed some of Spear's more

caustic remarks about individuals, but his irritation, particularly at historians with whom he disagreed, still comes across.

Another missing element is the Home Office Drugs Inspectorate itself. Very little has been written about this intriguing branch of the Civil Service, whose responsibilities date back to the Inebriates Acts of the nineteenth century, and no one was better placed to write an account of its work. But the book also does more than its title suggests, covering many drugs as well as heroin, including cocaine, the barbiturate use of the 1970s and amphetamines.

Bing Spear's uniqueness in the drugs field was the fusion of three strands. His role in the Drugs Inspectorate was pivotal, bringing him into contact with addicts, ministers, civil servants, doctors, the police, academics, pharmacists and pharmaceutical manufacturers. Secondly, he witnessed and took part in an historical period which saw some of the greatest changes in the UK's drug use, supply, treatment and policy responses. Added to these were his personal qualities, remarked upon by so many, which took his interest and concerns well beyond the job description.

As a researcher on drugs policy who never met Bing Spear, I find one of his most remarkable characteristics, emerging from oral history interviews and documents, was his ability, when debates raged fiercely, to retain the trust of all parties. In the bitter disputes over whether addicts should receive long-term 'maintenance' prescriptions, or injectable rather than oral methadone, and whether private doctors should be allowed to write prescriptions for controlled drugs, he was claimed as the champion of those on both sides, sometimes to exaggerated effect. Many doctors professed to be the inheritors and defenders of the 'British system' but their understanding of what this meant did not always match Spear's. Perhaps the fact that he enjoyed the support and confidence of such diverse interests reflected not only Spear's personal skills as a civil servant but also the indeterminate nature of the system itself.

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3 Mars S. Peer pressure and imposed consensus: the making of the 1984 'Guidelines of Good Clinical Practice in the Treatment of Drug Misuse'. In: Berridge V, ed. *Networks of Knowledge and Power: Science, Research and Policy since 1945*. Amsterdam: Rodopi (in press)

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Childhood Asthma and Other Wheezing Disorders

Second Edition Editor: Michael Silverman
484 pp Price: £95 ISBN 0-340-76318-3 (p/b)
London: Edward Arnold, 2002

Asthma has now reached epidemic proportions in many parts of the world. In the International Study of Allergies and Asthma in Childhood survey of almost half-a-million adolescents Britain ranked number one, with over one in four young people reporting that they had experienced at least one episode of wheezing in the preceding 12 months. National studies indicate that a similar proportion of British children have, at some point in their lives, been diagnosed with asthma. Whilst such population data are crucial for unravelling the aetiology of asthma and informing health services planning, they say nothing about the impact of asthma on individuals and their families. Interference with sport and leisure activities, disturbed sleep (both for children and their parents) and anxieties regarding the possible adverse effects of inhaled treatments are just some of the concerns that many healthcare professionals hear about daily when caring for young people with asthma.

Childhood Asthma and Other Wheezing Disorders aims to provide a 'comprehensive account of the biological basis and clinical management of asthma and childhood asthma

and other wheezing disorders', bringing together in one volume 'all the aspects necessary for full understanding by the trainee or practising respiratory physician, paediatrician or specialist nurse or therapist'. Several of the introductory chapters are dedicated to summarizing recent developments in the anatomy and physiology of the lung together with related advances in genetics and immunobiology.

As would be expected, the work provides a detailed critique of current thinking on the aetiology and pathogenesis of asthma and examines all aspects of treatment. The reader learns of the strength of evidence underpinning individual drug treatments and is offered guidelines for their use; but there is much more to high-quality asthma care than drugs, and the text also encourages professionals to consider the broader impact on individuals and society through chapters exploring the psychological, familial and public health aspects.

A strength of this book is that it successfully draws on the experiences of 49 contributors representing a broad range of clinical disciplines. Also they are geographically diverse, and an international dimension is provided by chapters on asthma in sub-Saharan Africa, south Asia, Latin America, Japan, Hong Kong and the Caribbean. Although the work follows the fashion by labelling itself evidence-based, there are signs that the editor and several of the contributors struggled with some basic principles of this art. They do not always recognize the importance of systematic searches or apply the hierarchy-of-evidence model. For example, a dominant theme in the chapter on asthma in primary care is the effectiveness of specialist asthma-trained nurses in delivering asthma care, yet there is no discussion of how various studies were selected for consideration, and no clear distinction is drawn between evidence from randomized controlled studies and evidence from audits.

This book is unlikely to appeal to those fanatical in their adherence to the evidence-based cult (for whom the current BMJ Books series, '*Evidence Based . . .*' is probably more appropriate). However, for clinicians who gain aesthetic satisfaction from a high-quality well-edited publication, this comprehensive, accessible and clinically useful reference text will serve its purpose well.

Aziz Sheikh
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Shelley's 77 Skins

W B Shelley, E D Shelley
77 flashcards Price: £31.99 ISBN 1-84214-106-6
London: Parthenon

This set of flashcards with illustrations of common dermatological disorders is marketed as a 'refresher course for doctors, nurses and students'. The stated claim is that 'when you know these, you know 95% of all you need to know'. Each card has an illustration and, on the reverse, some key features of the disease plus a catchy slogan such as for acne: 'from zits to pits'. I tried out the cards on a handful of dermatology consultants and specialist registrars, a new dermatology SHO, medical students, and a dermatology-phobic general practitioner (my husband). The consultants and specialist registrars did not do particularly well, finding that the skin appearance of some rashes suggested a wide differential. Without a history, a red patch on a back could be due to any number of conditions, but with a typical history a fixed drug eruption is easier to diagnose. In addition, some of the illustrations were atypical—for example, granuloma annulare is shown in its unusual widespread form rather than the typical ring on the back of a hand or dorsum of a foot. The SHO thought the cards were interesting and might be useful to flick through on starting dermatology. The medical students were a little bemused, finding the cards very difficult and the GP was exasperated with the chickenpox illustrations of two vesicles that could have been insect bites.

The concept is laudable and the quality of most of the illustrations is good. Some of the photos are excellent examples, such as the cutaneous larva migrans, psoriasis and the urticarial wheals. One glaring omission is melanoma (apart from the metastatic disease). Melanoma surely must rank in the need-to-know category. Disappointingly, the leg ulcer is out of focus and the aetiology is undefined. A good example of a venous ulcer and a punched out arterial ulcer would be useful additions.

The most likely users of these cards would be new dermatology SHOs or GP clinical assistants. If the target is to be doctors just starting out in dermatology, the illustrations need to be typical in appearance. Just a few changes and these cards could be really useful, and probably even more useful on a CD Rom.

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